U.S. Department of Labor

Office of Administrative Law Judges
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Pittsburgh, PA 15220

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DATE: December 13, 2000

CASE NO.: 2000-BLA-519

In the Matter of:

ROY L. FILES
Claimant

v.

U.S. STEEL MINING COMPANY, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances:

Ken Guin, Esquire
For the Claimant

James N. Nolan, Esquire
For the Employer

Before: ROBERT J. LESNICK
Administrative Law Judge

DECISION AND ORDER - AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et. seq. In accordance with the Act and the pertinent regulations, this case was referred to the

Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

A hearing was conducted in Birmingham, Alabama on September 19, 2000 at which time all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and the Regulations issued thereunder, found in Title 20, Code of Federal Regulations. During the hearing Director's Exhibits Nos. 1 through 34, Claimant's Exhibit No. 1, Employer's Exhibit No. 1 and Administrative Law Judge's Exhibits 1 through 3 were received in evidence.[1] No additional evidence was submitted post-hearing. All of this evidence has been made part of the record.

ISSUES

1.) Whether the Claimant has pneumoconiosis.

2.) Whether the Claimant's pneumoconiosis arose out of coal mine employment.

3.) Whether Claimant is totally disabled.

4.) Whether Claimant's total disability is due to pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background

Roy L. Files ("claimant" or "miner") filed his claim for benefits on February 2, 1999. (DX 1) On April 23, 1999, a claims examiner from the Officer of Workers' Compensation Programs ("OWCP") denied the claimant's application for benefits because the claimant failed to establish that he is totally disabled by pneumoconiosis. (DX 15) The claimant then requested the opportunity to submit additional evidence on June 23, 1999. (DX 16) Additional evidence was received by OWCP in connection with this claim. (DX 26 & 29) On January 18, 2000, the District Director issued a

[1] The following abbreviations have been used in this opinion: DX = Director's exhibits; EX = Employer's exhibits; CX = Claimant's exhibits; ALJX = Court exhibits; TR = Hearing Transcript; NR = Not recorded; BCR = Board-certified radiologist; B = B reader.

Proposed Decision and Order and Memorandum of Conference, having resolved the issues of dependency, length of coal mine employment and the properly designated responsible operator. (DX 30) The District Director found the claimant to be totally disabled due to pneumoconiosis that arose out of his coal mine employment with entitlement to benefits beginning in February, 1999. The employer requested a formal hearing before the Office of Administrative Law Judges on February 10, 2000. (DX 33) The employer was notified to begin payments to the claimant, however, because the employer had requested a hearing before the Office of Administrative Law Judges, the Black Lung Disability Trust Fund assumed payments to the claimant. (DX 31 & 32).

The claimant testified at the September 19, 2000 hearing that he began working in the coal mines in August, 1970. (TR 10) The claimant testified that from August, 1970 until January, 1999, the claimant worked exclusively underground. (TR 10) The claimant stated that while working underground in the coal mine, he was consistently exposed to coal dust. (TR 10) The claimant described his condition by stating that he cannot walk more than 50 feet without becoming short of breath. (TR 10) The claimant went on to say that his condition has been progressively worsening. (TR 11) The claimant also testified that he smoked cigarettes at a rate of a pack per day periodically for approximately 27 years. (TR 12-13) The claimant also stated that he is trying to quit his smoking habit. (TR 13) The claimant explained his smoking history as smoking 7 to 8 cigarettes per day occasionally, with the claimant ceasing his habit for a month or so and then starting to smoke again. (TR 14)

Medical Evidence

Chest X-Rays

Exhibit No.	***Date of X-ray***	***Date of Reading***	***Physician/ Qualifications***	***Interpretation***
DX 28	9-30-99	9-30-99	Goldstein, B	1/1
DX 27	5-12-99	10-11-99	Wiot, BCR/B	Negative
DX 12	3-3-99	3-3-99	Hasson, B	2/1
DX 13	3-3-99	4-15-99	Sargent, BCR/B	1/1
DX 24	3-3-99	8-24-99	Wiot, BCR/B	Negative
DX 27	8-4-98	10-11-99	Wiot, BCR/B	Negative
DX 24	7-9-98	8-24-99	Wiot, BCR/B	Negative
DX 24	11-5-97	8-24-99	Wiot, BCR/B	Negative

DX 24	9-5-96	8-24-99	Wiot, BCR/B	Negative
DX 24	1-24-94	8-24-99	Wiot, BCR/B	Unreadable
DX 24	6-22-84	8-24-99	Wiot, BCR/B	Negative

Pulmonary Function Studies

Ex. No.	***Date***	***Age***	***Height***	***FEV1***	***MVV***	***FVC***	***Tracings***	***Qualify***
DX 7	3-3-99	60	71	2.77	119	4.39	Yes	No
DX 23	8-14-98	59	72	3.16	114	4.65	Yes	No
DX 28	9-30-99	61	72	2.74 2.70*[2]	119 120*	4.45 4.61*	Yes	No

For a miner of Claimant's height of 71.5[3] inches, § 718.204 (c)(1) requires an FEV1 equal to or less than 2.17 for a male of 59 years of age, 2.15 for a male of 60 years of age, and 2.14 for a male of 61 years of age. If such a FEV1 value is shown, there must be in addition, an FVC equal to or less than 2.76, 2.74, and 2.72, respectively or an MVV equal to or less than 87, 86, 85, respectively; or a ratio equal to or less than 55% when the results of the FEV1 tests are divided by the results of the FVC test.

Arterial Blood Gas Tests

Exhibit No.	***Date***	***pO2***	***pCO2***	***Qualify***
DX 9	3-3-99	75.8 61.6**[4]	31.9 33.6**	No Yes

[2] The * represents that the results are post-bronchodilator treatment.

[3] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in this claim. *Protopappas v. Director, OWCP,* 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 3 (4th Cir. 1995). In this case, Mr. Files' listed height ranges from 71 to 72 inches. Taking the average of the heights listed, I find that claimant is 71.5 inches tall.

[4] The ** indicates that the results are post-exercise.

Physician Reports

Dr. Michael Sherman[5]

Dr. Michael Sherman issued a report in this claim on December 4, 1999. (DX 29) Dr. Sherman did not examine the claimant, but reviewed documentation that essentially constitutes the medical record in this claim. Dr. Sherman determined that the claimant suffers from chronic obstructive pulmonary disease ("COPD"). Dr. Sherman reaches this conclusion based on the claimant's symptoms of recurrent acute episodes of a sputum producing cough that has required multiple treatments with antibiotics and steroids. Dr. Sherman states that these symptoms are consistent with chronic bronchitis. Dr. Sherman diagnosed the claimant as suffering from progressive, mild obstructive lung disease. Dr. Sherman finds the cause of this condition to be coal mine dust exposure.

Dr. Sherman notes that the claimant has a significant history of coal dust exposure and that such exposure is "very likely" to have caused at least a portion of the claimant's COPD. Dr. Sherman also acknowledges that the claimant's 27 year smoking history is a major contributing factor to the claimant's condition. Dr. Sherman opines that both exposures are significant and both are significant factors in causing the claimant's condition. Dr. Sherman states that he is unable to partition the percentage of the impairment due to each exposure.

Dr. Sherman was also deposed in connection with this claim on July 19, 2000. (CX 1) Dr. Sherman explained his practice as involving critical care medicine and work in the intensive care unit. The practice involves a patient population suffering from chronic obstructive lung disease, bronchitis, emphysema, asthma, some occupational lung disease and lung cancer. Dr. Sherman elaborates on his December 4, 1999 diagnosis by stating that he based his diagnosis of COPD on the following evidence: (1) the claimant's pulmonary function study that showed a reduction in the FEV1 value; (2) Dr. Mosley's treatment notes that show dyspnea on exertion and recurring episodes of cough and bronchitis; (3) the decrease in the claimant's oxygen level with exercise; and (4) the changes in the claimant's x-ray films, and particularly the CT scan taken in August, 1998. Dr. Mosley goes on to state that the decrease in the claimant's oxygen level upon exercise is important because an oxygen level that

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[5] I take official notice of Dr. Sherman's credentials from the American Board of Medical Subspecialties. Dr. Sherman is Board Certified in critical care, internal medicine and pulmonary disease.

drops to 60 with exercise or a PO2 level that corrects to 60 when PCO2 is taken into account is the disability standard for respiratory impairments.

Dr. Sherman goes on to state that the oxygen level in a person without COPD increases instead of decreases. This basically illustrates that a person suffering from COPD cannot pump enough blood to the lungs because of the limited pulmonary vessels available because of the impairment. Dr. Sherman states that the resting PO2 level can be normal in a person who has an impairment in diffusion. However, when that person exerts physical effort, the heart rate increases and the blood flow through the lungs will decrease and the oxygen level drops. Dr. Sherman also stated that the CT scan of August, 1998 showed that the claimant suffers from emphysema, which Dr. Sherman describes as the "destruction of the part of the lung that exchanges oxygen and carbon dioxide." Dr. Sherman goes on to state that emphysema is a COPD that can be caused by smoking as well as by coal dust exposure. However, Dr. Sherman believes that the claimant's COPD was caused by coal dust exposure and that COPD plays a "significant role" in the claimant's impairment.

Dr. Sherman acknowledges that he did not find chest x-ray evidence of pneumoconiosis, but that such a finding is not necessary to diagnose the claimant with coal workers' pneumoconiosis. Dr. Sherman states that a clear x-ray reading, if taken with functional testing that illustrates an impairment can be indicative of coal workers' pneumoconiosis. Dr. Sherman concluded that the claimant is totally disabled from performing his last coal mine employment because his oxygen level drops with exertion and because of this, the claimant would be unable to operate a shuttle car. Dr. Sherman makes this diagnosis based on the claimant's pulmonary function study and arterial blood gas testing.

Dr. Sherman took issue with Dr. Wiot's diagnosis. Dr. Wiot diagnosed the claimant as suffering from idiopathic pulmonary fibrosis that does not indicate coal workers' pneumoconiosis. Dr. Sherman states that idiopathic pulmonary fibrosis can be present in many diseases, including coal workers' pneumoconiosis. Dr. Sherman states that idiopathic pulmonary fibrosis would be evidenced by a reduction in the claimant's FVC and FEV1 values in the pulmonary function study and such reductions are not present here.

Dr. Allan Goldstein[6]

Dr. Allan Goldstein saw the claimant on September 30, 1999 in connection with above-captioned claim. (DX 28) Dr. Goldstein notes 28 3/4 years of coal mine employment exposing the claimant to coal and rock dust on a daily basis. Dr. Goldstein also notes a cigarette smoking history of one pack per day for 25 to 30 years. The claimant stated a history of hypertension, shortness of breath for 1 to 2 years prior to the date of the examination, a dry cough and occasional wheezing. Dr.

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[6] I take official notice of Dr. Goldstein's credentials from the American Board of Medical Subspecialties. Dr. Goldstein is Board Certified in internal medicine and pulmonary disease.

Goldstein performed a pulmonary function study, arterial blood gas test and a chest x-ray on the date of the examination. Dr. Goldstein reported the results of the pulmonary function test as demonstrating an obstructive defect with significant improvement in the small airway flow rate, but still producing abnormal results after the administration of bronchodilation treatment. Dr. Goldstein interpreted the claimant's chest x-ray as showing increased interstitial linear markings in the mid and lower lung fields. Dr. Goldstein states that this result is not typically indicative of coal workers' pneumoconiosis.

Dr. Goldstein opines that the claimant's pulmonary function testing demonstrates an obstructive defect. Dr. Goldstein goes on to state that the claimant's pulmonary function results and shortness of breath are related to the claimant's smoking history, rather than the claimant's occupational history. However, Dr. Goldstein does state that he is unable to determine the exact etiology of the claimant's abnormal chest x-ray interpretation. Dr. Goldstein concludes by stating that he believes the claimant's condition is an obstructive airway disease, but that further evaluation is needed.

Dr. Jerry Mosley

Dr. Mosley, who states that he practices primarily internal medicine, gave a sworn statement in this claim on August 17, 1999. (DX 26) Included with the statement are numerous records of Dr. Mosley's extensive treatment of the claimant dating from 1984 to 1999. Dr. Mosley has treated the claimant for numerous problems over the aforementioned time span. Dr. Mosley states that these problems included chronic dyspnea on exertion and recurrent episodes of cough and bronchitis. Dr. Mosley also acknowledges that the claimant has been and currently is a smoker and such habit aggravates the claimant's underlying respiratory problems. Dr. Mosley explains that the claimant suffers from episodes of acute bronchitis that Dr. Mosley describes as bronchitis that occurs with a cold or any respiratory illness.

Dr. Mosley examined a chest x-ray of the claimant that Dr. Mosley interpreted to show interstitial scarring patterns consistent with coal workers' pneumoconiosis. Dr. Mosley states that the claimant is unable to perform his prior coal mine employment or any like employment because the claimant is "not capable of increasing energy expenditure without compromising his respiratory status." Dr. Mosley also states that the claimant is unable to lift any "sizeable weight on a regular basis." The claimant also suffers from significant dyspnea on exertion. Dr. Mosley diagnosed the claimant as suffering from coal workers' pneumoconiosis.

Dr. Mosley bases his diagnosis on the claimant's clinical history, chest x-rays, and diagnostic testing. Dr. Mosley also states that he reaches this conclusion based on the fact that the claimant has had significant exposure to coal dust and now has a pulmonary impairment. Dr. Mosley acknowledges that the claimant has a history of smoking cigarettes and coal dust exposure. Dr. Mosley opines that both of these factors contribute to the claimant's condition and the degree to which each contributes is impossible to determine. However, Dr. Mosley states that the claimant suffers from coal workers' pneumoconiosis as a direct result of his exposure to coal dust, thus rendering the claimant unable to

work in the coal mining industry and function in a position that requires the claimant to be underground. Dr. Mosley bases this on the clinical data concerning the claimant's condition and the physical requirements of the claimant's job. Dr. Mosley concludes by stating that the claimant's respiratory impairment is a direct result of the claimant's coal workers' pneumoconiosis.

Dr. Jerome Wiot

Dr. Jerome Wiot reviewed the following chest x-rays in this claim: June 22, 1984; January 24, 1994; September 5, 1996; November 5, 1997; July 9, 1998; and March 3, 1999. (DX 24) Dr. Wiot interpreted these x-ray films to be abnormal, but the abnormalities are not consistent coal workers' pneumoconiosis. Dr. Wiot found small irregular shadows in the mid and lower lung fields that have progressed since 1984. Dr. Wiot states that the abnormalities being found in the mid and lower fields are inconsistent with coal workers' pneumoconiosis. Dr. Wiot states that coal workers' pneumoconiosis begins in the upper lung fields and then spreads downward. Dr. Wiot also states that no form of pneumoconiosis would show a progression comparable to the claimant's condition. Dr. Wiot notes further that a condition such as idiopathic pulmonary fibrosis should be a strong consideration.

Dr. Wiot was also deposed in connection with this action on June 21, 2000. (EX 1) Dr. Wiot stated that he reviewed only the radiographic evidence in this claim. Dr. Wiot testified that he has been a board certified radiologist since 1959, and a certified B-Reader for approximately 16 years. Dr. Wiot found that the claimant's x-ray films of March, 1999, July, 1998, November, 1997, September, 1996 and June, 1984 showed no evidence of coal workers' pneumoconiosis. Dr. Wiot found that these films presented evidence of idiopathic pulmonary fibrosis not related to any occupational exposure. Dr. Wiot found the January, 1994 unreadable due to the foggy image. In comparing the November, 1997 film to that of the x-ray taken in June, 1984, Dr. Wiot found that there is no evidence of coal workers' pneumoconiosis. Dr. Wiot stated that coal workers' pneumoconiosis presents in rounded opacites in the lungs, and the opacites in the claimant's lungs are irregular shaped. Dr. Wiot made no finding as to whether the claimant was disabled by his condition.

Dr. Jack Hasson

Dr. Jack Hasson[7] issued a medical report on March 3, 1999 in connection with this claim. (DX 8) Dr. Hasson noted 19 years of coal mine employment on the date of the examination and the

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[7] I take official notice of Dr. Hasson's credentials from the American Board of Medical Subspecialties. Dr. Hasson is Board Certified in internal medicine, pulmonary disease and critical care medicine.

claimant's prior coal mine positions. The claimant's chief complaints included daily wheezing, dyspnea with a 1 to 2 block tolerance, and occasional paroxysmal nocturnal dyspnea. Dr. Hasson also conducted diagnostic testing on the date of the examination that included a chest x-ray, pulmonary function test and arterial blood gas study. Dr. Hasson interpreted the chest x-ray as showing pneumoconiosis. Dr. Hasson also notes that the pulmonary function study produced normal results and the arterial blood gas study showed mild hypoxemia at rest and a fall in the claimant's PO2 level with exercise.

Dr. Hasson diagnosed the claimant as suffering from moderate simple pneumoconiosis arising out of the claimant's history of coal mine employment and mild "HCVD." Dr. Hasson bases his finding of pneumoconiosis on the claimant's occupational history, diagnostic testing and chest x-ray. Dr. Hasson attributes a majority of the claimant's impairment to his pneumoconiosis and a minority of the impairment to the HCVD.

Conclusions of Law

Length of Coal Mine Employment

The claimant claims 27 years of coal mine employment. (ALJX 1) The employer stipulated to 27 years of coal mine employment. (ALJX 2) Therefore, I find that claimant was a coal miner within the meaning of the Act for 27 years.

Responsible Operator

The designation of U.S. Steel Mining Company, Inc. as the responsible operator has gone uncontested in this action. (DX 20) Therefore, I find that U.S. Steel Mining Company, Inc. is the properly designated responsible operator and will provide for the payment of any benefits awarded to the claimant.

Dependents

The issue of the dependency of the claimant's wife, Johnnie, has gone uncontested in this claim. Accordingly, I find that Johnnie qualifies as a dependent for the purposes of augmentation under the Act.

Existence of Pneumoconiosis

The regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§718.304, 718.305 and 728.306, and medical opinions. §718.202(a)(1)-(4). There is no evidence of complicated pneumoconiosis, and claimant is a living miner who filed his claim after January 1, 1982, he is not eligible for the presumptions in §§

718.304, 718.305, 718.306.

The first method provided in the regulations to establish the existence of pneumoconiosis is by chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). There are eleven interpretations of nine different x-ray films contained in the record as part of claimant's claim for benefits. Three of the eleven readings are positive for pneumoconiosis. Of the three readings, two were rendered by certified B Readers and one was rendered by a dually-qualified physician. There are seven interpretations that are negative for the existence of pneumoconiosis. All seven of the interpretations were rendered by the same dually-qualified physician. There is also one interpretation of the January, 24, 1994 x-ray, interpreted by Dr. Wiot, that finds the x-ray film to be unreadable.

A judge is not required to defer to the numerical superiority of x-ray evidence. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990). Where two or more x-ray reports are in conflict, the radiological qualifications of the physicians interpreting the x-rays must be considered. (See 20 C.F.R. § 718.202 (a)(1)). Great weight may be given to B-Readers due to their expertise. *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-689 (1985). The interpretations of dually qualified physicians are entitled to more weight than the interpretations of B-Readers. *Herald v. Director, OWCP*, B.R.B. No. 94-2354 BLA (Mar. 23, 1995) (unpublished). If the film quality is "poor" or "unreadable," then the study may be given little weight. *Gober v. Reading Anthracite Co.*, 12 B.L.R. 1-67 (1988).

I accord the most weight to the interpretations of dually qualified physicians contained in the record. I also accord great weight to the interpretations of the B-Readers. I find that the x-ray interpretations dated July 9, 1998; November 5, 1997; September 5, 1996; and June 22, 1984 are entitled to less weight because they were classified with a quality reading of "3." The x-ray film dated January 24,1994 is also entitled to little weight because it was interpreted to be unreadable.

Weighing the remaining interpretations, I find that the numerical positive and negative readings are in equipose. Therefore, I accord greater weight to the interpretations of the dually-qualified physicians. Thus, I find that the claimant has failed to establish the existence of pneumoconiosis by a preponderance of the x-ray evidence.

The claimant has failed to establish the existence of pneumoconiosis by the second and third methods because there is no biopsy evidence and he is a living miner who filed a claim after 1982 without evidence of complicated pneumoconiosis. 20 C.F.R. §§ 718.202(a)(2) and (a)(3).

The fourth method available to the claimant to establish the existence of pneumoconiosis is by a reasoned medical opinion from a physician establishing that the claimant suffers from a respiratory or pulmonary impairment arising out of coal mine employment or by meeting the definition of pneumoconiosis provided at 20 C.F.R. § 718.201. 20 C.F.R. § 718.202(a)(4). Section 718.201 defines pneumoconiosis as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment...[a] disease 'arising out of coal mine employment' includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment

significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

Five physician opinions appear as part of the record. Dr. Sherman opined that the claimant suffers from chronic obstructive pulmonary disease. Dr. Sherman bases this opinion on the claimant's symptoms, the claimant's pulmonary function study, Dr. Mosley's treatment notes, the drop in the claimant's oxygen level with exercise and the claimant's x-ray films. Dr. Sherman states that the claimant's condition was caused by the claimant's exposure to coal dust. Thus, Dr. Sherman has diagnosed the claimant with legal pneumoconiosis because Dr. Sherman finds that the claimant suffers from a respiratory condition that was caused by the claimant's exposure to coal dust. Dr. Mosley also found that the claimant suffers from coal workers' pneumoconiosis. Dr. Mosley bases that opinion on the fact that Dr. Mosley has been the claimant's treating physician for approximately 16 years as well as his own observations and diagnostic testing of the claimant in those years. Dr. Hasson also finds that the claimant suffers from coal workers' pneumoconiosis. Dr. Hasson found that the claimant suffers from moderate simple pneumoconiosis. Dr. Hasson bases his finding on the claimant's occupational history, diagnostic testing and chest x-rays.

Drs. Goldstein and Wiot found that the claimant does not suffer from coal workers' pneumoconiosis. Dr. Goldstein opines that the claimant's pulmonary function study produced abnormal results after bronchodilation treatment, which is not indicative of pneumoconiosis. Dr. Goldstein also bases his opinion on the fact that the claimant's x-rays show that the claimant's lungs are diseased in the mid and lower fields which is not typical of pneumconiosis. Dr. Goldstein relates the claimant's condition to his history of cigarette smoking and not coal dust exposure. However, Dr. Goldstein is unable to determine the exact etiology of the claimant's abnormal chest x-ray interpretations. Dr. Wiot also finds that the claimant does not suffer from pneumoconiosis. Dr. Wiot bases his opinion on an examination of the claimant's x-ray films. Dr. Wiot finds that the abnormalities present in the claimant's x-rays are not consistent with coal workers' pneumoconiosis. Dr. Wiot also states that the claimant's abnormalities are found in the upper lung fields and coal workers' pneumoconiosis is usually present in the lower lung fields. Dr. Wiot also opines that the progress of the claimant's impairment is not typical of coal workers' pneumoconiosis. Dr. Wiot finds that the claimant suffers from idiopathic pulmonary fibrosis, unrelated to the claimant's coal dust exposure.

I accord greater weight to the opinion of Drs. Sherman, Hasson and Mosley. More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWCP,* 14 B.L.R. 1-2 (1989). Dr. Mosley has treated the miner for approximately 16 years and therefore, his opinion is entitled to greater weight. A medical report containing the most recent physical examination of the miner may be properly accorded greater weight as itis likely to contain a more accurate evaluation of the miner's current condition. *Gillespie v. Badger Coal Co.,* 7 B.L.R. 1-839 (1985). Dr. Sherman is the most recent physician to examine the claimant. Therefore, I accord greater weight to the opinion of Dr. Sherman. I also find the opinion of Dr. Hasson to be well-reasoned and well-documented.

Dr. Goldstein states that the claimant's condition is not coal workers' pneumoconiosis, but does not reach a conclusion as to the claimant's condition. Dr. Goldstein finds that the claimant's condition is related to the claimant's history of cigarette smoking, but does not make any conclusive finding as to the claimant's condition. Accordingly, I find that Dr. Goldstein's opinion is entitled to less weight. Dr. Wiot, while presenting a detailed report bases his opinion on only the x-ray evidence contained in the record. Therefore, Dr. Wiot's opinion as to the claimant's condition is not supported by the data contained in the record as a whole.

I find that the opinion of Drs. Sherman, Hasson and Mosley to be better supported by the objective medical data, and to be well-reasoned and well-documented considering the evidence contained in the record and therefore entitled to greater weight. Accordingly, I find that the claimant has established the existence of pneumoconiosis by a preponderance of the reasoned medical opinion evidence.

Arising Out of Coal Mine Employment

In order to receive benefits, the claimant must show that his pneumoconiosis arose out of his coal mine employment. As claimant has twenty-seven (27) years of coal mine employment, he is entitled to the rebuttable presumption at § 718.203(b) that his pneumoconiosis arose out of his coal mine employment. Because the employer has failed to offer evidence sufficient to rebut the presumption, I find that claimant's pneumoconiosis arose out of his coal mine employment.

Total Disability

Total disability is defined as pneumoconiosis which prevents or prevented a miner from performing his usual coal mine employment or other gainful work. §§ 718.305(c), 718.204(b). Section 718.204 sets out the standards for determining total disability. This section provides that in the absence of contrary probative evidence, evidence which meets the standards at § 718.204(c)(1)-(5) shall establish the miner's total disability.

Total disability may be established by pulmonary function testing. 20 C.F.R. § 718.204(c)(1). None of the pulmonary function studies contained in the record produce qualifying values under the regulations. Therefore, I find that the claimant has failed to establish by a preponderance of the pulmonary function tests evidence that he is totally disabled under the provisions of (c)(1).

The claimant can also establish total disability with qualifying arterial blood gas testing that meets the regulation standards. 20 C.F.R. § 718.204(c)(2). There is one arterial blood gas study in the record. The resting test result does not produce qualifying values. However, upon the administration of exercise, the test result qualifies under the applicable regulations. A blood gas study is

designed to measure the ability of the lung to oxygenate blood. A lower level of oxygen compared to carbon dioxide in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

A blood sample taken after exercise is very helpful in that exercise requires that the body be able to oxygenate blood more quickly. An insufficiency in gas transfers may be noted after exercise before they are evident at rest. Thus, the results of the blood gas test after exercise are highly probative on the issue of total disability. Because the results after the administration of exercise produce qualifying values under the regulations, I find that those results are more probative on the issue of the claimant's disability. Based on these test results, I find that the claimant has established total disability pursuant to 20 C.F.R. § 718.204 (c)(2).

There is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, total disability is not established under 20 C.F.R. § 718.204(c)(3). Total disability may also be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concluded that the claimant's respiratory or pulmonary impairment prevents him from engaging in his usual coal mine work or in comparable and gainful employment.

Drs. Sherman and Mosley find that the claimant is totally disabled by his pulmonary condition. Dr. Sherman states that the claimant is totally disabled from performing his last coal mine employment because the claimant's oxygen level drops with exertion and this would render the claimant unable to perform the requirements of his last coal mine job of shuttle car operator. Dr. Mosley opines that the claimant is unable to perform his last coal mine employment because the claimant is "not capable of increasing energy expenditure without compromising his respiratory status," thus rendering the claimant unable to work in an underground coal mining environment. Dr. Goldstein does not speak to the disabling nature of the claimant's condition. Rather, Dr. Goldstein states that the claimant has a obstructive airway disease, but does not state whether the claimant's condition is disabling. Dr. Hasson finds that the claimant's condition is "moderate." This is not indicative of a finding of total disability. Dr. Wiot does not offer an opinion as to whether the claimant's condition is disabling. Considering that Dr. Hasson does not offer an explanation for his characterization of the claimant's condition as moderate and Drs. Sherman and Mosley present well-reasoned rationale for their opinions, I find that the claimant has established total disability by a preponderance of the physician medical report evidence.

Etiology of Total Disability

In a part 718 claim, such as this, claimant has the burden of proving not only total disability, but also that the total disability is due to pneumoconiosis. Even if the arterial blood gas tests and pulmonary function studies are qualifying to prove total disability, the Benefits Review Board has consistently held that blood gas tests and pulmonary function studies are not diagnostic of the etiology of respiratory

impairment, but are diagnostic only of the severity of the impairment. *Tucker v. Director, OWCP*, 10 B.L.R. 1-35, 1-41 (1987). Thus a claimant who established total disability through arterial blood gas tests or pulmonary function studies has not also established that the disability is due to pneumoconiosis. *Id.* The Eleventh Circuit requires that pneumoconiosis be a "substantial contributor" to the miner's total disability. *Lollar v. Alabama-By-Products,* 893 F.2d 1258, 1265 (11th Cir. 1990).

The cause of a miner's total disability may be shown through the reasoned medical opinion of a qualified physician. There are five physician opinions contained in the record. Dr. Goldstein's report states that the claimant's condition is related to the claimant's smoking history, however, Dr. Goldstein also states that he is unable to determine the exact cause of the claimant's abnormal chest x-rays. Dr. Wiot makes no findings as to the claimant's disability or the cause thereof. Dr. Hasson, while not concluding that the claimant's impairment was totally disabling, did find that the claimant's pneumoconiosis was responsible for the majority of the claimant's impairment. Drs. Sherman and Mosley both find that the claimant's condition was caused by both the claimant's history of cigarette smoking and coal dust exposure. Neither physician was able to determine the amount of the disability attributable to each cause. However, both agree that the claimant's exposure to coal dust is, at the least, a significant factor contributing to the claimant's pulmonary impairment. Therefore, I find that the claimant has established by a preponderance of the physician opinion evidence that pneumoconiosis is a substantial contributor to the claimant's disabling respiratory impairment.

Entitlement

Upon consideration of all of the evidence of record, I find that claimant has met his burden of proof on all elements of entitlement under the Act and is therefore eligible for benefits.

Date of Onset of Disability

Section 725.503(b) provides that payment of benefits is to commence with the month of the onset of total disability, but if the evidence does not establish the month of onset, payment of benefits shall begin with the month in which the claim was filed. Since the evidence is unclear as to the date of onset of the miner's total disability, due to pneumoconiosis, benefits will be awarded as of February 1, 1999, the first day of the month in which the claim was filed.

Attorney's Fees

An application by claimant's attorney for approval of a fee has not been received and, therefore, no award of attorney's fees for services is made. Thirty days is hereby allowed to claimant's counsel for the submission of such an application and attention is directed to Sections 725.365 and 725.366 of the regulations. A service sheet showing that service has been made upon all parties, including claimant, must accompany the application. Parties have ten days following the receipt of any such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

It is hereby ordered that the claim of Roy L. Files for benefits the Black Lung Benefits Act is hereby GRANTED.

It is further ordered that the employer, U.S. Steel Mining Company, Inc. shall pay to the claimant all benefits to which he is entitled under the Act commencing February 1, 1999.[8]

ROBERT J. LESNICK
Administrative Law Judge

[8] 20 C.F.R. § 725.530 (within 30 days of this order). In any case in which the fund has paid benefits on behalf of an operator or employer, the latter shall simultaneously with the first payment of benefits to the beneficiary, reimburse the fund (with interest) for the full amount of all such payments. 20 C.F.R. § 725.602(a).

If an employer does not pay benefits after the Director's initial determination of eligibility, it may be ordered to pay the beneficiary simple interest on all past due benefits at a rate according to the Internal Revenue Code§ 6621. 20 C.F.R. §§ 725.608(a) and 725.608(c).

RJL/JBM

NOTICE OF APPEAL RIGHT: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order by filing notice of appeal with the ***Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of notice of appeal must also be served on *Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.*